Staff Health Screening Form

Date: _____ Child Care Program: _____

Please answer the following questions to the best of your ability:

Staff's Name	Do you have a fever, cough, sore throat, or shortness of breath? Y or N	Have you or anyone in the household traveled outside the country in the past month? Y or N	Have you come into contact with anyone who has tested positive with COVID-19? Y or N	Is anyone in your household experiencing signs of illness? Y or N	Staff's temperature	Staff signature (agreeing to the information)	2nd Staff person's initials

*Centers for Disease Control and Prevention – Coronavirus Disease 2019 (COVID-19) How to Protect Yourself- https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html

March 23, 2020